

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0038083</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Lexington of LaGrange</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>4735 Willow Springs Road</u> <u>LaGrange</u> <u>60525</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		(Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>( 708 ) 352-6900</u> <b>Fax #</b> <u>( 708 ) 482-0239</u>		(Type or Print Name) _____	
<b>IDPA ID Number:</b> <u>363835751001</u>		(Title) _____	
<b>Date of Initial License for Current Owners:</b> <u>07/31/92</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
<b>Type of Ownership:</b>		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input type="checkbox"/> Charitable Corp.		(Telephone) <u>( 312 ) 634-3400</u> <b>Fax #</b> <u>( 312 ) 634-5518</u>	
<input type="checkbox"/> Trust		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<b>IRS Exemption Code</b> _____		SEE ACCOUNTANTS' COMPILATION REPORT	
<input checked="" type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> GOVERNMENTAL			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input checked="" type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>( 312 ) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

Facility Name & ID Number Lexington of LaGrange# 0038083 Report Period Beginning: 01/01/02 Ending: 12/31/02

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>12,336</u>	<u>13,301</u>	<u>5,554</u>	<u>31,191</u>	8
9	SNF/PED					9
10	ICF	<u>5,631</u>	<u>1,569</u>	<u>100</u>	<u>7,300</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,967</u>	<u>14,870</u>	<u>5,654</u>	<u>38,491</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 96.75%

D. How many bed-hold days during this year were paid by Public Aid?

131 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been  
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 07/31/92

J. Was the facility purchased or leased after January 1, 1978?

YES ☐Date New constructionNO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐If YES, enter number  
of beds certified 40 and days of care provided 5,081Medicare Intermediary AdminaStar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH\* ☐CASH\* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/02 Ending: 12/31/02

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	224,818	16,792	7,797	249,407		249,407		249,407			1
2	Food Purchase		152,129		152,129		152,129	(7,368)	144,761			2
3	Housekeeping	183,648	22,706		206,354		206,354	375	206,729			3
4	Laundry	36,275	12,728		49,003		49,003	(9,523)	39,480			4
5	Heat and Other Utilities			128,071	128,071		128,071	2,004	130,075			5
6	Maintenance	41,762		82,918	124,680		124,680	1,028	125,708			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	486,503	204,355	218,786	909,644		909,644	(13,484)	896,160			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,797,301	97,826	8,285	1,903,412		1,903,412		1,903,412			10
10a	Therapy			419,234	419,234		419,234		419,234			10a
11	Activities	160,381	7,331	3,102	170,814		170,814		170,814			11
12	Social Services	29,124		2,959	32,083		32,083		32,083			12
13	Nurse Aide Training											13
14	Program Transportation			2,837	2,837		2,837		2,837			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,986,806	105,157	454,417	2,546,380		2,546,380		2,546,380			16
	<b>C. General Administration</b>											
17	Administrative	150,043		257,252	407,295		407,295	(257,252)	150,043			17
18	Directors Fees											18
19	Professional Services			40,951	40,951		40,951	178	41,129			19
20	Dues, Fees, Subscriptions & Promotions			9,986	9,986		9,986	472	10,458			20
21	Clerical & General Office Expenses	303,847	29,809	17,438	351,094		351,094	8,885	359,979			21
22	Employee Benefits & Payroll Taxes			365,685	365,685		365,685	36,847	402,532			22
23	Inservice Training & Education			153	153		153		153			23
24	Travel and Seminar			2,587	2,587		2,587	1,573	4,160			24
25	Other Admin. Staff Transportation			313	313		313	5,158	5,471			25
26	Insurance-Prop.Liab.Malpractice			120,994	120,994		120,994	1,714	122,708			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	453,890	29,809	815,359	1,299,058		1,299,058	(202,425)	1,096,633			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,927,199	339,321	1,488,562	4,755,082		4,755,082	(215,909)	4,539,173			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

\*\*See schedule of adjustments attached at end of cost report.

Facility Name &amp; ID Number

Lexington of LaGrange

#0038083

Report Period Beginning:

01/01/02

Ending:

12/31/02

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			35,008	35,008		35,008	100,824	135,832			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							186,806	186,806			32
33	Real Estate Taxes							247,943	247,943			33
34	Rent-Facility & Grounds			843,692	843,692		843,692	(843,692)				34
35	Rent-Equipment & Vehicles			5,309	5,309		5,309	2,369	7,678			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			884,009	884,009		884,009	(305,750)	578,259			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		114,253	11,629	125,882		125,882		125,882			39
40	Barber and Beauty Shops			19,748	19,748		19,748		19,748			40
41	Coffee and Gift Shops			2,848	2,848		2,848		2,848			41
42	Provider Participation Fee			59,677	59,677		59,677		59,677			42
43	Other (specify):* <b>Nonallowable Costs</b>			108,957	108,957		108,957	(108,957)				43
44	<b>TOTAL Special Cost Centers</b>		114,253	202,859	317,112		317,112	(108,957)	208,155			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,927,199	453,574	2,575,430	5,956,203		5,956,203	(630,616)	5,325,587			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\* See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(9,523)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(420)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(976)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(700)	43		18
19	Entertainment				19
20	Contributions	(815)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(89,448)	43		24
25	Fund Raising, Advertising and Promotional	(12,918)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(4,100)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(8,768)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (127,668)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(502,948)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (502,948)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (630,616)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of LaGrangeID# 0038083Report Period Beginning: 01/01/02Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

**Lexington Health Care Center of Lagrange**  
**Provider # 0038083**  
**1/1/02 - 12/31/02**

**Schedule A**

Schedule VI. Adjustment detail  
Line 29, Other

Description	Amount	Reference
Nonallowable collections	(5,114)	19
Nonallowable Chamber of Commerce dues	(525)	20
Miscellaneous income offset	(167)	21
Nonallowable miscellaneous expense	(3,438)	21
Deferred maintenance amort.	476	6
Total	<u>(8,768)</u>	

**See Accountants' Compilation Report**

## Summary A

12/31/02

12/31/02

[illegible]



Facility Name &amp; ID Number Lexington of LaGrange

# 0038083

Report Period Beginning:

01/01/02

Ending:

12/31/02

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Sambell of LaGrange		
				Limited Partnership	LaGrange	Real Estate ptsp.
See attached Schedule B		See attached Schedule B		Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C. II	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rental expense	\$ 843,692	Sambell of LaGrange Limited Partnership	**	\$	\$ (843,692)	1
2	V	19 Professional fees		Sambell of LaGrange Limited Partnership	**	3,220	3,220	2
3	V	21 Office supplies		Sambell of LaGrange Limited Partnership	**	111	111	3
4	V	21 Bank charges		Sambell of LaGrange Limited Partnership	**	75	75	4
5	V	30 Depreciation		Sambell of LaGrange Limited Partnership	**	86,928	86,928	5
6	V	32 Interest expense		Sambell of LaGrange Limited Partnership	**	183,200	183,200	6
7	V	32 Amortization of mortgage costs		Sambell of LaGrange Limited Partnership	**	1,777	1,777	7
8	V	33 Property taxes		Sambell of LaGrange Limited Partnership	**	243,692	243,692	8
9	V							9
10	V			** The owners of Lexington Health Care Center of LaGrange, Inc. own 100%				10
11	V			of Sambell of LaGrange Limited Partnership				11
12	V							12
13	V							13
14	Total		\$ 843,692			\$ 519,003	\$ * (324,689)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Lagrange Inc.**  
**Provider # 0038083**  
**1/1/02 - 12/31/02**

**Schedule B**

VII. Related Parties  
Owners

<u>Name</u>	<u>Ownership %</u>
James Samatas Discretionary Trust	22.33%
John Samatas Discretionary Trust	22.33%
Cynthia Thiem Discretionary Trust	22.34%
Jeffrey J. Bell Revocable Trust	8.25%
Lawrence W. Bell Revocable Trust	8.25%
David S. Bell Revocable Trust	8.25%
David S. Bell 2001 Trust	2.75%
Jeffrey J. Bell 2001 Trust	2.75%
Lawrence W. Bell 2001 Trust	2.75%

<u>Name of facility</u>	<u>City</u>
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling
Lexington Health Care Center of Orland Park, Inc.	Orland Park

**See Accountants' Compilation Report**

Facility Name &amp; ID Number Lexington of LaGrange

# 0038083

Report Period Beginning: 01/01/02

Ending: 12/31/02

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 Housekeeping supplies	\$	Royal Management Corp.	**	\$ 375	\$ 375 15
16	V	5 Utilities - gas & electric		Royal Management Corp.	**	1,909	1,909 16
17	V	5 Utilities - water & sewer		Royal Management Corp.	**	95	95 17
18	V	6 Repairs & maintenance		Royal Management Corp.	**	520	520 18
19	V	6 Scavenger & exterminating		Royal Management Corp.	**	24	24 19
20	V	6 Security service		Royal Management Corp.	**	8	8 20
21	V	19 Computer consultant & supplies		Royal Management Corp.	**	4,140	4,140 21
22	V	19 Professional fees		Royal Management Corp.	**	1,057	1,057 22
23	V	20 Advertising - help wanted		Royal Management Corp.	**	599	599 23
24	V	20 Dues & subscriptions		Royal Management Corp.	**	398	398 24
25	V	21 Bank charges		Royal Management Corp.	**	1,381	1,381 25
26	V	21 Communications		Royal Management Corp.	**	276	276 26
27	V	21 Office supplies & printing		Royal Management Corp.	**	5,234	5,234 27
28	V	21 Postage		Royal Management Corp.	**	1,644	1,644 28
29	V	21 Telephone		Royal Management Corp.	**	3,769	3,769 29
30	V	22 FICA		Royal Management Corp.	**	15,890	15,890 30
31	V	22 FUTA		Royal Management Corp.	**	292	292 31
32	V	22 SUTA		Royal Management Corp.	**	319	319 32
33	V	22 Insurance - W/C		Royal Management Corp.	**	368	368 33
34	V	22 Insurance - hospitalization		Royal Management Corp.	**	9,243	9,243 34
35	V	22 401(k) and other emp. benefits		Royal Management Corp.	**	3,367	3,367 35
36	V	24 Travel & seminar		Royal Management Corp.	**	1,573	1,573 36
37	V						
38	V	**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.					
39	Total		\$			\$ 52,481	\$ * 52,481 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Lexington of LaGrange

# 0038083

Report Period Beginning: 01/01/02

Ending: 12/31/02

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	25 Auto expense	\$	Royal Management Corp.	**	\$ 5,158	\$ 5,158 15
16	V	26 Insurance - general		Royal Management Corp.	**	1,714	1,714 16
17	V	30 Depreciation - vehicles		Royal Management Corp.	**	1,840	1,840 17
18	V	30 Depreciation - leasehold improv.		Royal Management Corp.	**	3,613	3,613 18
19	V	30 Depreciation - equipment		Royal Management Corp.	**	8,443	8,443 19
20	V	32 Interest		Royal Management Corp.	**	2,249	2,249 20
21	V	33 Property taxes		Royal Management Corp.	**	1,126	1,126 21
22	V	35 Equipment rental		Royal Management Corp.	**	2,369	2,369 22
23	V	17 Management fees	257,252	Royal Management Corp.	**		(257,252) 23
24	V						24
25	V						25
26	V						26
27	V						27
28	V						28
29	V						29
30	V						30
31	V						31
32	V						32
33	V						33
34	V						34
35	V						35
36	V						36
37	V						37
38	V	**Certain owners of Lexington Health Care Center of LaGrange, Inc. own 100% of Royal Management Corp.					38
39	Total		\$ 257,252			\$ 26,512	\$ * (230,740) 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange # 0038083 Report Period Beginning: 01/01/02 Ending: 12/31/02

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	2	4.00%	Salary	\$ 19,416	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	1	5.00%	Salary	8,629	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	1	5.00%	Salary	10,787	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	1	5.00%	Salary	2,589	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	3	6.00%	Salary	6,538	L 17, C 1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 47,959		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington Health Care Center of Lagrange Inc.**  
**Provider # 0038083**  
**1/1/02 - 12/31/02**

**Schedule C**

VII. Related Parties

C. Statement of Compensation and Other Payments to Owners, Relatives  
and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

<u>Name of facility</u>	<u>John Samatas</u>	<u>James Samatas</u>	<u>Cynthia Thiem</u>	<u>George Samatas</u>	<u>Jason Samatas</u>	<u>Total</u>
Lexington Health Care Center of Bloomingdale, Inc.	13,617	30,638	17,021	4,085	10,318	75,679
Lexington Health Care Center of Chicago Ridge, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Elmhurst, Inc.	11,875	26,719	14,844	3,563	8,998	65,999
Lexington Health Care Center of Lake Zurich, Inc.	16,071	36,160	20,089	4,821	12,177	89,318
Lexington Health Care Center of Lombard, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Orland Park, Inc.	21,376	48,096	26,721	6,413	16,194	118,800
Lexington Health Care Center of Schaumburg, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Streamwood, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Wheeling, Inc.	17,496	39,367	21,870	5,249	13,258	97,240
<hr/>						
Total	151,371	340,584	189,213	45,411	114,693	841,272

**See Accountants' Compilation Report**

Facility Name & ID Number Lexington of LaGrange# 0038083 Report Period Beginning: 01/01/02 Ending: 12/31/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Royal Management Corp.  
 Street Address 665 W. North Avenue, Suite 500  
 City / State / Zip Code Lombard, IL 60148  
 Phone Number ( 630) 458-4700  
 Fax Number ( 630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	\$ 6,954	\$ 39,785	\$ 375	1	
2	5	Utilities - gas & electric	Bed Days	737,665	10	35,380	39,785	1,908	2	
3	5	Utilities - water & sewer	Bed Days	737,665	10	1,765	39,785	96	3	
4	6	Repairs & maintenance	Bed Days	737,665	10	9,640	39,785	520	4	
5	6	Scavenger & exterminating	Bed Days	737,665	10	438	39,785	24	5	
6	6	Security service	Bed Days	737,665	10	150	39,785	8	6	
7	19	Computer consultant & supplies	Bed Days	737,665	10	76,767	39,785	4,140	7	
8	19	Professional fees	Bed Days	737,665	10	19,590	39,785	1,057	8	
9	20	Advertising - help wanted	Bed Days	737,665	10	11,111	39,785	599	9	
10	20	Dues & subscriptions	Bed Days	737,665	10	7,373	39,785	398	10	
11	21	Bank charges	Bed Days	737,665	10	25,613	39,785	1,381	11	
12	21	Communications	Bed Days	737,665	10	5,118	39,785	276	12	
13	21	Office supplies & printing	Bed Days	737,665	10	97,051	39,785	5,234	13	
14	21	Postage	Bed Days	737,665	10	30,484	39,785	1,644	14	
15	21	Telephone	Bed Days	737,665	10	69,873	39,785	3,769	15	
16	22	FICA	Bed Days	737,665	10	294,613	39,785	15,890	16	
17	22	FUTA	Bed Days	737,665	10	5,419	39,785	292	17	
18	22	SUTA	Bed Days	737,665	10	5,907	39,785	319	18	
19	22	Insurance - W/C	Bed Days	737,665	10	6,829	39,785	368	19	
20	22	Insurance - hospitalization	Bed Days	737,665	10	171,371	39,785	9,243	20	
21	22	401(k) and other emp. benefits	Bed Days	737,665	10	62,427	39,785	3,367	21	
22	24	Travel & seminar	Bed Days	737,665	10	29,161	39,785	1,573	22	
23										23
24										24
25	TOTALS					\$ 973,034	\$	\$ 52,481		25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange# 0038083

Report Period Beginning:

01/01/02Ending: 12/31/02

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

Royal Management Corp.

Street Address

665 W. North Avenue, Suite 500

City / State / Zip Code

Lombard, IL 60148

Phone Number

( 630) 458-4700

Fax Number

( 630) 458-4796

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	\$ 95,636	\$ 39,785	\$ 5,158	1
2	26	Insurance - general	Bed Days	737,665	10	31,776	39,785	1,714	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	34,112	39,785	1,840	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	66,995	39,785	3,613	4
5	30	Depreciation - equipment	Bed Days	737,665	10	156,541	39,785	8,443	5
6	32	Interest	Bed Days	737,665	10	41,692	39,785	2,249	6
7	33	Property taxes	Bed Days	737,665	10	20,881	39,785	1,126	7
8	35	Equipment rental	Bed Days	737,665	10	43,917	39,785	2,369	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 491,550	\$	\$ 26,512	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	7		8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Lexington Financial						\$				\$	1
2	Services, L.L.C. II	x		Mortgage	\$22,735.00	12/29/98	2,990,000	2,672,736	12/29/2008	0.0675	183,200	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$22,735.00		\$ 2,990,000	\$ 2,672,736			\$ 183,200	9
	B. Non-Facility Related*											
10								Amortization of loan costs			1,777	10
11								Interest income offset			(420)	11
12								Allocated from management company			2,249	12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ 3,606	14
15	TOTALS (line 9+line14)						\$ 2,990,000	\$ 2,672,736			\$ 186,806	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Lexington of LaGrange**# **0038083** Report Period Beginning: **01/01/02** Ending: **12/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	<b>216,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		Allocated from Management Company	\$	<b>1,126</b>	
		2001	\$	<b>220,342</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$	<b>5,468</b>	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	<b>240,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	<b>3,125</b>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.					
<b>TOTAL REFUND</b> \$ <b>650</b> For <b>1995</b> Tax Year. <b>(Attach a copy of the real estate tax appeal board's decision.)</b>			\$	<b>(650)</b>	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	<b>247,943</b>	7

  

Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	<b>195,909</b>	8
	1998	<b>198,451</b>	9
	1999	<b>196,475</b>	10
	2000	<b>208,552</b>	11
	2001	<b>220,342</b>	12

  

<b>2001 taxes:</b>	<b>220,342</b>		
<b>Estimated increase (9.5%):</b>	<b>1,095</b>		
<b>Estimated 2002 taxes:</b>	<b>241,274</b>		
<b>Use:</b>	<b>240,000</b>		

  

	<b>FOR OHF USE ONLY</b>	
13	FROM R. E. TAX STATEMENT FOR 2001 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Lexington of LaGrange COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038083

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE ( 630 ) 458-4700 FAX #: ( 630 ) 458-4795

**A. Summary of Real Estate Tax Costs**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>18-08-207-018-000</u>	<u>Land and building</u>	\$ <u>220,341.68</u>	\$ <u>220,341.68</u>
2. <u>Royal Managment Corp. (Omni Partners)</u>		\$ _____	\$ _____
3. <u>06-19201-018</u>	<u>Land and building</u>	\$ <u>70,162.04</u>	\$ <u>79.00</u>
4. <u>Royal Managment Corp. (Samvest</u>		\$ _____	\$ _____
5. <u>05-01-202-019</u>	<u>Land and building</u>	\$ <u>144,399.48</u>	\$ <u>1,047.00</u>
6. _____		\$ _____	\$ _____
7. _____		\$ _____	\$ _____
8. _____		\$ _____	\$ _____
9. _____		\$ _____	\$ _____
10. _____		\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>434,903.20</u>	\$ <u>221,467.68</u>

**B. Real Estate Tax Cost Allocation:**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? \_\_\_\_\_ YES \_\_\_\_\_ X \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,992
 B. General Construction Type:
 Exterior Concrete Block
 Frame Steel
 Number of Stories 2

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO
 If so, please complete the following:

1. Total Amount Incurred: N/A
 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A
 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	40,000	1991	\$ 500,000	1
2	Allocated from Management Company			8,781	2
3	TOTALS	40,000		\$ 508,781	3

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 12

Facility Name &amp; ID Number Lexington of LaGrange

# 0038083

Report Period Beginning:

01/01/02

Ending:

12/31/02

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	99	1992	1992	\$ 2,661,448	\$	35	\$ 76,041	\$ 76,041	\$ 798,434
5	10	1995	1995	79,363	7,936	10	7,936		59,522
6									
7									
8									
Improvement Type**									
9	Land Improvements	1992		1,152		20	58	58	606
10	Building Improvements	1992		2,714		31	136	136	2,714
11	Building Improvements	1993		2,901		35	83	83	787
12	Leasehold Improvements	1994		6,402	640	10	640		5,442
13	Leasehold Improvements - Corner Guards	1996		2,195	219	10	219		1,427
14	Wiring	1998		3,378	338	10	338		1,520
15	Resurface & Restripe Parking Lot	1998		3,753	375	10	375		1,689
16	Lobby Tile	1998		19,488	1,949	10	1,949		8,120
17	Resurface & Restripe Parking Lot	2000		1,997	200	10	200		499
18	Automatic Door	2000		1,300	130	10	130		325
19	Kitchen Rehab	2001		1,441	144	10	144		216
20	Infrared curtains for elevator	2001		3,000	300	10	300		450
21	Dining room, resident rooms, and corridors renovation	2002		150,083	625	20	625		625
22	Elevator upgrade	2002		5,399	360	10	360		360
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Leasehold improvements - management company	1995	\$ 5,566	\$	35	\$ 202	\$ 202	\$ 1,193		37
38	Leasehold improvements - management company	1996	4,529		35	164	164	841		38
39	Leasehold improvements - management company	1989	156		31	6	6	73		39
40	HVAC - management company	1998	117		35	4	4	17		40
41	Offices - management company	1999	296		35	11	11	30		41
42	Offices - management company	2000	140		35	5	5	11		42
43	Land improvements - management company	2002	5,267		15	322	322	322		43
44	Building - management company	2002	122,791		40	2,814	2,814	2,814		44
45	Sewer & water improvements - management company	2002	2,793		30	85	85	85		45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 3,087,669	\$ 13,216		\$ 93,147	\$ 79,931	\$ 888,122		70

Facility Name &amp; ID Number Lexington of LaGrange

# 0038083

Report Period Beginning:

01/01/02

Ending:

12/31/02

## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 326,517	\$ 19,085	\$ 29,695	\$ 10,610	5-10 years	\$ 283,892	71
72	Current Year Purchases	28,614	2,707	2,707		5-10 years	2,707	72
73	Fully Depreciated Assets	7,388					7,388	73
74	Allocated from Management Company	84,324		8,443	8,443		22,056	74
75	TOTALS	\$ 446,843	\$ 21,792	\$ 40,845	\$ 19,053		\$ 316,043	75

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79	Allocated from Management Company			16,468		1,840	1,840		11,460	79
80	TOTALS			\$ 16,468	\$	\$ 1,840	\$ 1,840		\$ 11,460	80

## E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 4,059,761	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 35,008	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 135,832	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 100,824	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,215,625	85

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

## G. Construction-in-Progress

	Description	Cost	
92	Bed additions	\$ 49,385	92
93			93
94			94
95		\$ 49,385	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 7,678 Description: Copier - \$4,325; Postage Meter - \$984; Allocated from Management Company - \$2,369

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2003 \$                     

13.                      /2004 \$                     

14.                      /2005 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

**A. TYPE OF TRAINING PROGRAM** (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, C3	hrs	\$	15,057	\$ 159,041	\$	15,057	\$ 159,041	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		1,540	22,519		1,540	22,519	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		16,888	237,674		16,888	237,674	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				114,253		114,253	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Schedule D					11,629			11,629	13
14	TOTAL			\$	33,485	\$ 430,863	\$ 114,253	33,485	\$ 545,116	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

**Lexington of LaGrange**  
**Provider #: 0038083**  
**01/01/02 to 12/31/02**

**Schedule D**

XIV. Special Services (Direct Cost)  
Line 13, Other

<u>Service</u>	<u>Cost</u>	<u>Line Reference</u>
Oxygen	6,789	L 39, C3
Laboratory	2,080	L 39, C3
Radiology	2,760	L 39, C3
Total	<u>11,629</u>	

**See Accountants' Compilation Report**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 311,271	\$ 314,698	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 338,394 )	946,955	946,955	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	47,455	47,455	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	17,222	17,222	8
9	Other(specify): Escrow		96,180	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,322,903	\$ 1,422,510	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	3,732	3,732	12
13	Land		508,781	13
14	Buildings, at Historical Cost		2,664,349	14
15	Leasehold Improvements, at Historical Cost	277,799	423,320	15
16	Equipment, at Historical Cost	147,158	463,311	16
17	Accumulated Depreciation (book methods)	(159,297)	(1,215,625)	17
18	Deferred Charges		238	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify: Construction in progr		49,385	22
23	Other(specify): Unamortized loan costs		28,425	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 269,392	\$ 2,925,916	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 1,592,295	\$ 4,348,426	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 180,713	\$ 180,713	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	309,861	309,861	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	213,188	213,188	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,421	1,421	31
32	Accrued Real Estate Taxes(Sch.IX-B)		240,000	32
33	Accrued Interest Payable		15,034	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See attached Schedule E	163,727	60,721	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 868,910	\$ 1,020,938	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		2,672,736	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 2,672,736	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 868,910	\$ 3,693,674	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 723,385	\$ 654,752	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 1,592,295	\$ 4,348,426	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**Lexington Health Care Center of Lagrange, Inc.**  
**Provider # 0038083**  
**1/1/02 - 12/31/02**

**Schedule E**

XV. Balance Sheet  
C. Current Liabilities

36. Other Current Liabilities

<u>Description</u>	<u>Operating</u>	<u>After Consolidation</u>
Accrued Rent	103,006	
Accrued management fees	17,373	17,373
Accrued 401 (k) contribution	13,728	13,728
401 (k) withholding	3,957	3,957
Other accrued expenses	25,663	25,663
Total line 36	<u>163,727</u>	<u>60,721</u>

XVII. Income Statement  
E. Other Revenue

28. Other Revenue

<u>Description</u>	<u>Amount</u>
Investment in Lexington Financial Services, L.L.C. II	167
State bedhold income	11,804
Miscellaneous income	468
Total line 28	<u>12,439</u>

**See Accountants' Compilation Report**

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,006,653	1
2	Restatements (describe):		2
3	Prior period adjustment	(82,407)	3
4	Prior year's post closing entries	(122,514)	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 801,732	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	803,653	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(882,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (78,347)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 723,385	24 *

Operating Entity Only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Lexington of LaGrange

# 0038083

Report Period Beginning: 01/01/02

Ending:

12/31/02

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note:** This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 6,090,143	1
2	Discounts and Allowances for all Levels	(342,916)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,747,227	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	743,444	6
7	Oxygen	2,093	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 745,537	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	2,427	12
13	Barber and Beauty Care	22,004	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	15	15
16	Rental of Facility Space		16
17	Sale of Drugs	128,919	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	14,407	19
20	Radiology and X-Ray	3,289	20
21	Other Medical Services	73,649	21
22	Laundry	9,523	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 254,233	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	420	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 420	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>See attached Schedule E</b>	12,439	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 12,439	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,759,856	30

2			
	Expenses	Amount	
<b>A. Operating Expenses</b>			
31	General Services	909,644	31
32	Health Care	2,546,380	32
33	General Administration	1,299,058	33
<b>B. Capital Expense</b>			
34	Ownership	884,009	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	257,435	35
36	Provider Participation Fee	59,677	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 5,956,203	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	803,653	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 803,653	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.  
This entity files a cash basis return.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Lexington of LaGrange**# **0038083**Report Period Beginning: **01/01/02**Ending: **12/31/02****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,146	2,472	\$ 94,831	\$ 38.36	1
2	Assistant Director of Nursing	1,947	2,092	55,255	26.41	2
3	Registered Nurses	21,178	22,928	571,931	24.94	3
4	Licensed Practical Nurses	17,272	18,461	376,881	20.41	4
5	Nurse Aides & Orderlies	55,084	57,880	638,171	11.03	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,339	4,697	60,232	12.82	8
9	Activity Director	2,023	2,112	32,096	15.20	9
10	Activity Assistants	12,620	13,240	128,285	9.69	10
11	Social Service Workers	1,682	1,883	29,124	15.47	11
12	Dietician					12
13	Food Service Supervisor	1,947	2,083	32,750	15.72	13
14	Head Cook	2,011	2,035	23,469	11.53	14
15	Cook Helpers/Assistants	12,722	13,451	108,882	8.09	15
16	Dishwashers	8,910	9,363	59,717	6.38	16
17	Maintenance Workers	2,767	2,894	41,762	14.43	17
18	Housekeepers	24,371	25,997	183,648	7.06	18
19	Laundry	5,376	5,614	36,275	6.46	19
20	Administrator	2,241	2,368	102,084	43.11	20
21	Assistant Administrator					21
22	Other Administrative	359	359	47,959	133.59	22
23	Office Manager					23
24	Clerical	17,173	18,431	303,847	16.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	196,168	208,360	\$ 2,927,199 *	\$ 14.05	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	145	\$ 7,797	L 1, C 3	35
36	Medical Director	Monthly	18,000	L 9, C 3	36
37	Medical Records Consultant	Monthly	600	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,102	L 11, C 3	44
45	Social Service Consultant	66	2,959	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	211	\$ 33,658		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Lexington of LaGrange**# **0038083**Report Period Beginning: **01/01/02**Ending: **12/31/02****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership %	Amount	D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function			Description	Amount	Description	Amount
Deborah Morris	Administrator	0.00%	\$ 102,084	Workers' Compensation Insurance	\$ 51,075	IDPH License Fee	\$
John Samatas	Admin/Plant Ops	22.33%	8,629	Unemployment Compensation Insurance	14,456	Advertising: Employee Recruitment	7,084
James Samatas	Administrative	22.33%	19,416	FICA Taxes	215,822	Health Care Worker Background Check	
Cynthia Thiem	Administrative	22.34%	10,787	Employee Health Insurance	92,043	(Indicate # of checks performed <u>23</u> )	266
George Samatas	Administrative	0.00%	2,589	Employee Meals	7,368	Miscellaneous licenses & permits	970
Jason Samatas	Administrative	0.00%	6,538	Illinois Municipal Retirement Fund (IMRF)*		Miscellaneous dues & subscriptions	1,141
				401 (k) Contributions	15,370		
				Other Employee Benefits	6,398		
TOTAL (agree to Schedule V, line 17, col. 1)							
(List each licensed administrator separately.)			\$ 150,043				
B. Administrative - Other							
Description			Amount				
Management fees (eliminated in column 7)			\$ 257,252				
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 257,252				
(Attach a copy of any management service agreement)							
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description
ING	401 (k) administration		\$ 550				Out-of-State Travel
Altschuler, Melvoin & Glasser LLP	Accounting		14,397				
American Express Tax & Bus Srv	Accounting		5,468				
Systematic Management	Billing Consulting		108	N/A			In-State Travel
Freedman, Anselmo & Lindberg	Collections		5,114				
Katten Muchin Zavis and Rosenman	Legal		868				
Personnel Planners	U/C Consulting		1,151				
James Samatas	Legal		73				Seminar Expense
Harris Kessler & Goldstein, LLC	Legal		4,178				2,587
Internet Presence Consulting	Computer Consulting		711				
Carol Jeschke	Staffing Consultant		738				Allocated from Management Company
See attached Schedule F			7,595				1,573
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	Entertainment Expense (agree to Sch. V, line 24, col. 8)
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 40,951				TOTAL
							\$ 4,160

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

**Lexington of LaGrange****Provider #: 0038083****1/1/02 - 12/31/02****Schedule F**XIX. Support Schedules  
C. Professional Services

<u>Vendor/Payee</u>	<u>Type</u>	<u>Amount</u>
Advanced Answers on Demand, Inc.	Computer Consulting	3,247
Action Computer Service, Inc.	Computer Consulting	324
Sachnoff & Weaver	Legal	2,829
Glantz-Richman	Rehabilitation Consultant	350
Gigatrend	Computer Consulting	195
Information Controls, Inc.	Computer Consulting	650
Total, Other Professional Services		<u>7,595</u>
Total, Agrees to Schedule V, Line 19, Column 3		40,951
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/		
American Express Tax & Business Services	Accounting	394
Brekke Consulting, Inc.	Exec. Counsel Consulting	91
Gilson, Labus and Silverman	Accounting	24
James Samatas	Legal	11
Katten, Muchin, Zavis and Rosenman	Legal	119
Sachnoff and Weaver	Legal	65
ING / Pension Administrators / Aetna Life Insurance & Annuity Co	401 (k) Administration	293
Various	Consulting	4,200
Allocated from building partnership		
James Samatas	Filing and recording fees	95
McCracken, Walsh, de Lavan, & Hetler	Real estate tax appeal	3,125
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(5,114)
McCracken, Walsh, de Lavan, & Hetler	Reclassified to property tax	(3,125)
Total, Agrees to Schedule V, Line 19, Column 8		<u>41,129</u>

**See accountants' compilation report.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

(Continued from Page 1)													
1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting & Decorating	Various 2000	\$ 1,428	3 years	\$	\$ 238	\$ 476	\$ 476	\$ 238	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 1,428		\$	\$ 238	\$ 476	\$ 476	\$ 238	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of LaGrange

STATE OF ILLINOIS

# 0038083

Report Period Beginning:

01/01/02

Ending:

Page 23

12/31/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 34,534 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 59,677  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 7,368 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
d. Have vehicle usage logs been maintained? Adequate records have been maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

## RECONCILIATION REPORT

Lexington of LaGrange

03:22 PM

11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-630,616	equal to	-630,616	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	186,806	equal to	186,806	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	247,943	equal to	247,943	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	135,832	equal to	135,832	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	7,678	equal to	7,678	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	419,234	equal to	419,234	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	114,253	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	909,644	equal to	909,644	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,546,380	equal to	2,546,380	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,299,058	equal to	1,299,058	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	884,009	equal to	884,009	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	257,435	equal to	257,435	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	59,677	equal to	59,677	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,737,069	equal to	1,797,301	-60,232	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	160,381	equal to	160,381	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	29,124	equal to	29,124	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	224,818	equal to	224,818	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	41,762	equal to	41,762	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	183,648	equal to	183,648	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	36,275	equal to	36,275	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	150,043	equal to	150,043	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	303,847	equal to	303,847	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,927,199	equal to	2,927,199	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	7,797	< or = to	7,797	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	18,000	< or = to	18,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,800	< or = to	8,285	-6,485	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	3,102	< or = to	3,102	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,959	< or = to	2,959	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	150,043	equal to	150,043	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	257,252	equal to	257,252	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	40,951	equal to	40,951	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	402,532	equal to	402,532	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	10,458	equal to	10,458	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,160	equal to	4,160	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	59,677	equal to	59,677	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	7,368	< or = to	36,847	-29,479	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	7,368	equal to	7,368	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	5,081	equal to	5,554	-473	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-502,948	equal to	-502,948	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	2,672,736	equal to	2,672,736	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	240,000	equal to	240,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	508,781	equal to	508,781	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	3,087,669	equal to	3,087,669	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	463,311	equal to	463,311	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,215,625	equal to	1,215,625	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	723,385	equal to	723,385	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	803,653	equal to	803,653	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	238	equal to	238	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,592,295	equal to	1,592,295	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	224,818	16,792	7,797	249,407	0	249,407	0	249,407
2. Food P	0	152,129	0	152,129	0	152,129	-7,368	144,761
3. Housek	183,648	22,706	0	206,354	0	206,354	375	206,729
4. Laundry	36,275	12,728	0	49,003	0	49,003	-9,523	39,480
5. Heat ar	0	0	128,071	128,071	0	128,071	2,004	130,075
6. Mainte	41,762	0	82,918	124,680	0	124,680	1,028	125,708
7. Other (	0	0	0	0	0	0	0	0
8. Total G	486,503	204,355	218,786	909,644	0	909,644	-13,484	896,160
9. Medical	0	0	18,000	18,000	0	18,000	0	18,000
10. Nursin	1,797,301	97,826	8,285	1,903,412	0	1,903,412	0	1,903,412
10a. Ther	0	0	419,234	419,234	0	419,234	0	419,234
11. Activi	160,381	7,331	3,102	170,814	0	170,814	0	170,814
12. Social	29,124	0	2,959	32,083	0	32,083	0	32,083
13. Nurse	0	0	0	0	0	0	0	0
14. Progr	0	0	2,837	2,837	0	2,837	0	2,837
15. Other	0	0	0	0	0	0	0	0
16. Total I	1,986,806	105,157	454,417	2,546,380	0	2,546,380	0	2,546,380
17. Admin	150,043	0	257,252	407,295	0	407,295	-257,252	150,043
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	40,951	40,951	0	40,951	178	41,129
20. Fees,	0	0	9,986	9,986	0	9,986	472	10,458
21. Cleric	303,847	29,809	17,438	351,094	0	351,094	8,885	359,979
22. Emplo	0	0	365,685	365,685	0	365,685	36,847	402,532
23. Inserv	0	0	153	153	0	153	0	153
24. Travel	0	0	2,587	2,587	0	2,587	1,573	4,160
25. Other	0	0	313	313	0	313	5,158	5,471
26. Insura	0	0	120,994	120,994	0	120,994	1,714	122,708
27. Other	0	0	0	0	0	0	0	0
28. Total C	453,890	29,809	815,359	1,299,058	0	1,299,058	-202,425	1,096,633
29. Total C	2,927,199	339,321	1,488,562	4,755,082	0	4,755,082	-215,909	4,539,173
30. Depre	0	0	35,008	35,008	0	35,008	100,824	135,832
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	0	0	0	0	186,806	186,806
33. Real E	0	0	0	0	0	0	247,943	247,943
34. Rent -	0	0	843,692	843,692	0	843,692	-843,692	0
35. Rent -	0	0	5,309	5,309	0	5,309	2,369	7,678
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	884,009	884,009	0	884,009	-305,750	578,259
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	114,253	11,629	125,882	0	125,882	0	125,882
40. Barbe	0	0	19,748	19,748	0	19,748	0	19,748
41. Coffee	0	0	2,848	2,848	0	2,848	0	2,848
42. Provid	0	0	59,677	59,677	0	59,677	0	59,677
43. Other	0	0	108,957	108,957	0	108,957	-108,957	0
44. Total S	0	114,253	202,859	317,112	0	317,112	-108,957	208,155
45. Grand	2,927,199	453,574	2,575,430	5,956,203	0	5,956,203	-630,616	5,325,587

	After	Consolidation
General Service Cost Center		
1. Cash on	311,271	314,698
2. Cash - F	0	0
3. Account	946,955	946,955
4. Supply I	0	0
5. Short-T	0	0
6. Prepaid	47,455	47,455
7. Other Pi	0	0
8. Account	17,222	17,222
9. Other (s	0	96,180
10. Total c	1,322,903	1,422,510
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	3,732	3,732
13. Land	0	508,781
14. Buildin	0	2,664,349
15. Lease	277,799	423,320
16. Equipn	147,158	463,311
17. Accum	-159,297	#####
18. Deferre	0	238
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other I	0	49,385
23. other (:	0	28,425
24. Total L	269,392	2,925,916
25. Total A	1,592,295	4,348,426
CURRENT LIABILITIES		
26. Accour	180,713	180,713
27. Officer	0	0
28. Accour	309,861	309,861
29. Short-T	0	0
30. Accrue	213,188	213,188
31. Accrue	1,421	1,421
32. Accrue	0	240,000
33. Accrue	0	15,034
34. Deferre	0	0
35. Federa	0	0
36. Other (	163,727	60,721
37. Other (	0	0
38. Total C	868,910	1,020,938
LONG TERM LIABILITES		
39. Long-T	0	0
40. Mortga	0	2,672,736
41. Bonds I	0	0
42. Deferre	0	0
43. Other L	0	0
44. Other L	0	0
45. Total L	0	2,672,736
46. Total Li	868,910	3,693,674
47. Total Ei	723,385	654,752
48. Total Li	1,592,295	4,348,426

Balance per  
Medicaid  
Trial Balance

1. Gross F 6,090,143  
2. Discour -342,916

Subtota 5,747,227  
4. Day Ca 0  
5. Other C 0  
6. Therap 743,444  
7. Oxygen 2,093

Subtota 745,537  
9. Paymer 0  
10. Other 0  
11. Nurse 0  
12. Gift an 2,427  
13. Barber 22,004  
14. Non-P 0  
15. Teleph 15  
16. Rental 0  
17. Sale o 128,919  
18. Sale o 0  
19. Labor 14,407  
20. Radiol 3,289  
21. Other 73,649  
22. Laund 9,523

Subtot 254,233  
24. Contril 0  
25. Interest 420

Subtot 420  
27. Other 12,439  
28. Other 0  
Subtot 12,439

30. Total F 6,759,856  
31. Gener 909,644  
32. Health 2,546,380  
33. Gener 1,299,058  
34. Owner 884,009  
35. Specie 257,435  
35. Provid 59,677  
37. Other 0  
40. Total F 5,956,203  
41. Incom 803,653  
42. Incom 0  
43. Net In 803,653

Page

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9 Line 16 for mortgage insurance.

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